d. Notes and loans receivable from owners or related organizations;

e. Goodwill;

f. Unpaid capital surplus;

g. Treasury Stock;

h. Unrealized capital appreciation surplus;

i. Cash surrender value of life insurance policies;

j. Prepaid premiums on life insurance policies;

k. Assets acquired in anticipation of expansion and not used in the provider's operations or in the maintenance of patient care activities during the rate period;

l. Inter-company accounts;

m. Funded depreciation;

n. Cash investments that are long term (more than six months);

o. Deferred tax liability attributed to non-allowable tax expense;

p. Any other assets not directly related to or necessary for the provision of patient care;

q. Net capitalized loan/financing costs;

r. Resident fund accounts held on behalf of the resident which were included on the facility s balance sheet;

S. Workmen s Compensation self insurance fund.

G. Total Base Rate

The annual base rate is the sum of the standard direct care per diem rate, the care related per diem rate, the administrative and operating per diem rate, the per diem property payment, the per diem hold harmless payment, and the per diem return on equity payment.

3-5 Occupancy Allowance

The fixed per diem costs for administrative and operating costs and for property will be calculated using the greater of the facility's actual occupancy level or eighty percent (80%). This level is considered to be the minimum occupancy level for economic and efficient operation.

For facilities having less than eighty percent (80%) occupancy, the number of total patient days will be computed on an eighty percent (80%) factor instead of a lower actual percentage of occupancy. This will not apply to the computation of patient days used in computing the direct care and care related rates. For example: a facility with an occupancy level of seventy percent (70%) representing 20,000 actual patient days in a reporting period will have to adjust this figure to 22,857 patient days ((22,000 / 70%)

X 80%) to equal a minimum of eighty percent (80%) occupancy. Reserved bed days will be counted as an occupied bed for this computation.

Facilities having an occupancy rate of less than eighty percent (80%) should complete Form 14 when submitting their cost report.

3-6 State Owned NF's

NF's that are owned by the State of Mississippi will be included in the rate setting process described above in order to calculate a prospective rate for each facility. However, after the facilities file their cost report, the per diem rate for each cost report period will be adjusted to the actual allowable cost for that period, subject to the Medicare upper limit.

3-7 Adjustments to the Rate for Changes in Law or Regulation

Adjustments will be made to the rate as necessary to comply with changes in state or federal law or regulation.

CHAPTER 4
RATE COMPUTATION - ICF-MR'S

4-1 Rate Computation - ICF-MR's - General Principles

It is the intent of the Division of Medicaid to reimburse Intermediate Care Facilities for the Mentally Retarded a rate that is adequate for an efficiently and economically operated facility. An efficiently and economically operated facility is defined as one with direct care costs, therapy costs, care related costs, and administrative and operating costs less than 110% of the median, property costs that do not require a payment of the hold harmless provision and an occupancy rate of 80% or more.

4-2 Computation of Rate for Intermediate Care Facilities for the Mentally Retarded

A per diem rate will be established annually, unless this plan requires a rate being calculated at another time, for the period July 1 through June 30 until June 30, 2000. The rates established for the period July 1, 1999 through June 30, 2000 will be trended forward to establish rates for the period July 1, 2000 through December 31, 2000 as described in the Computation of Per Diem Rate for Nursing Facilities section (Section 3-4) of this plan. Beginning January 1, 2001, the per diem rate year will be January 1 through December 31, unless this plan requires a rate being calculated at another time. Cost reports used to calculate the rate will be the cost report filed for the period ending in the second calendar year prior to the beginning of the next calendar rate year, unless this plan requires a short period cost report to be used to compute the facility rate. For example, the rates effective January 1, 2001 will be determined from cost reports filed for the cost report year ended in 1999 unless a

short period cost report and rate calculation is required by other provisions of this plan. Costs used in the rate calculations may be adjusted by the amount of anticipated increase in costs or decrease in costs due to federal or state laws or federal regulations. A description of the calculation of the rate is as follows:

A. Direct Care, Therapies, Care Related, and Administrative and Operating Rate Determination

1. Determine the per diem cost for direct care costs, therapies, care related costs, and administrative and operating costs for each facility during the cost report period. This is done by adding the total allowable costs for these cost centers and dividing the result by the total patient days.

2. Trend each facility's per diem cost as determined in 1, above, to the middle of the rate year using the ICF-MR and PRTF Trend Factor. This is done by multiplying the ICF-MR and PRTF Trend Factor in order to trend costs forward from the mid-point of

of the cost report period to the mid-point of the payment period.

3. Array the trended costs from the lowest cost to the highest cost.

4. Determine the ceiling for direct care costs, therapies, care related costs, and administrative and operating costs. The ceiling is based on 110% of the cost associated with the median patient day. The median is determined by accumulating the annualized total patient days for each facility in the array described in 3, above. The trended cost that is associated with the mid-point of the total patient days is determined by multiplying the total patient days by fifty percent (50%) and interpolating to determine the median cost. The cost at the median is multiplied by 110% to determine the ceiling.

5. Determine the per diem rate for each facility for direct care costs, therapies, care related costs and administrative and operating costs. If the facility's cost is above the ceiling, its rate is the ceiling. If the facility falls below the

ceiling, then its rate is its trended cost plus fifty percent (50%) of the difference between the trended cost or the median, whichever is greater, and the ceiling.

B. Property Payment. A per diem payment will be made for property costs based on a fair rental system. The amount of the payment is determined as follows:

1. A new facility constructed on January 1, 1992 is assumed to have a per bed value of $31,090, which is the per bed value of a nursing facility multiplied by one hundred twenty percent (120%). The value of new construction of a nursing facility bed will be indexed each year using the RS Means Construction Cost Index. The indexed value of new construction of a nursing facility bed will be multiplied by one hundred twenty percent (120%). The new bed value will be indexed each year to January 1 of the payment year. The cost index for the payment year will be estimated by using a five-year moving average of the most recent cost indices for Jackson, MS.

2. Existing facilities, one year or older, will be valued at the new construction bed value less depreciation of 1% per year according to the age of the facility. Facilities will not be depreciated to an amount less than 30% of the new construction bed value. Facilities which were constructed in one year and then added additional beds in later years will be valued based upon the original construction date for the original beds and the added beds will be valued based upon their construction date.

3. The per bed value will be multiplied by the number of beds in the facility to estimate the facility's total current value.

4. A rental factor will be applied to the facility's total current value to estimate its annual fair rental value. The rental factor is determined by using the average Medicare rate for the calendar year preceding the rate period with a lower limit of seven and one-half percent (7.5%) per annum and an imposed upper limit of ten percent (10%) per annum. The rental factor is multiplied by the facility's total value, as determined in 3, above, to determine the annual fair rental value.

5. The annual fair rental value will be divided by the facility's annualized total patient days during the cost report period to determine the fair rental per diem payment. Annualized total patient days will be adjusted to reflect changes in the number of certified beds by applying to the increase or decrease the occupancy rate reported on the cost report used to set rates. Patient days will be adjusted, if necessary, to 80% occupancy.

6. Property taxes and property insurance will be annualized and divided by annualized total patient days to determine a per diem amount for these costs and will be passed through as an addition to the fair rental per diem payment. Patient days will be adjusted to reflect changes in the number of certified beds and, if necessary, to 80% occupancy.

7. The total of the fair rental per diem payment and the per diem property taxes and insurance is the per diem property payment.

8. The hold harmless provision for capital costs must be computed as described in Chapter 6 of this plan to determine the per diem hold harmless payment for each facility.

C. Return on Equity Payment

The facility's average net working capital for the reporting period maintained for necessary and proper operation of patient care activities will be multiplied by the rental factor used in the property payment to determine the return on equity payment. The return on equity payment will be divided by annualized patient days for the cost report period used to set the rate to calculate the per diem return on equity payment. The facility's net working capital will be limited to two (2) months of the facility's allowable costs, including property-related costs. In effect, net working capital is the net worth of the provider (owners' equity in the net assets as determined under the Medicaid program) excluding net property, plant, and equipment, and liabilities associated therewith, and those assets and liabilities